AN ACT

ENTITLED, An Act to revise and update certain provisions related to the South Dakota Life and Health Insurance Guaranty Association.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. This Act shall be known and may be cited as the South Dakota Life and Health Insurance Guaranty Association Act.

Section 2. A. The purpose of this Act is to protect, subject to certain limitations, the persons specified in subpart A of section 3 of this Act against failure in the performance of contractual obligations, under life and health insurance policies and annuity contracts specified in subpart B of section 3 of this Act, because of the impairment or insolvency of the member insurer that issued the policies or contracts.

B. To provide this protection, an association of insurers is organized to pay benefits and to continue coverages as limited by this Act, and members of the association are subject to assessment to provide funds to carry out the purpose of this Act.

Section 3. A. This Act shall provide coverage for the policies and contracts specified in subpart B:

(1) To persons who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are the beneficiaries, assignees, or payees of the persons covered under subdivision (2);

(2) To persons who are owners of or certificate holders under the policies or contracts (other than structured settlement annuities) and in each case who:

(a) Are residents; or

(b) Are not residents, but only under all of the following conditions:

(i) The insurer that issued the policies or contracts is domiciled in this state;

(ii) The states in which the persons reside have associations similar to the association created by this Act;

(iii) The persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in the state at the time specified in the state's guaranty association law;

(3) For structured settlement annuities specified in subpart B, subdivisions (1) and (2) of this subpart do not apply, and this Act shall (except as provided in subdivisions (4) and (5) of this subpart) provide coverage to a person who is a payee under a structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:

(a) Is a resident, regardless of where the contract owner resides; or

(b) Is not a resident, but only under both of the following conditions:

(i) (I) The contract owner of the structure settlement annuity is a resident, or (II) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the contract owner resides has an association similar to the association created by this Act; and

(ii) Neither the payee (or beneficiary) nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides;

(4) This Act does not provide coverage to a person who is a payee (or beneficiary) of a contract owner resident of this state, if the payee (or beneficiary) is afforded any coverage by the association of another state;

(5) This Act is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person

who would otherwise receive coverage under this Act is provided coverage under the laws of any other state, the person may not be provided coverage under this Act. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or assignee, this Act shall be construed in conjunction with other state laws to result in coverage by only one association.

B. (1) This Act shall provide coverage to the persons specified in subpart A for direct, nongroup life, health, or annuity policies or contracts and supplemental contracts to any of these and for certificates under direct group policies and contracts, except as limited by this Act. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts.

(2) This Act may not provide coverage for:

(a) A portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner;

(b) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(c) A portion of a policy or contract to the extent that the rate of interest on which it is based:

(i) Averaged over the period of four years prior to the date on which the association becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the association became obligated; and

(ii) On and after the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(d) A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association, or other person under:

(i) A multiple employer welfare arrangement as defined in 29 U.S.C. § 1144;

(ii) A minimum premium group insurance plan;

(iii) A stop-loss group insurance plan; or

(iv) An administrative services only contract;

(e) A portion of a policy or contract to the extent that it provides for:

(i) Dividends or experience rating credits;

(ii) Voting rights; or

(iii) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(f) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(g) A portion of a policy or contract to the extent that the assessments required by section 9 of this Act with respect to the policy or contract are preempted by federal

or state law;

(h) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

(i) Claims based on marketing materials;

(ii) Claims based on side letters, riders, or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;

(iii) Misrepresentations of or regarding policy benefits;

(iv) Extra-contractual claims; or

(v) A claim for penalties or consequential or incidental damages;

(i) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(j) An unallocated annuity contract; and

(k) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this Act, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture

under this subsection, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture.

C. The benefits that the association may become obligated to cover may in no event exceed the lesser of:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(2) (a) With respect to one life, regardless of the number of policies or contracts:

(i) Three hundred thousand dollars in life insurance death benefits, but not more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;

(ii) In health insurance benefits:

(I) One hundred thousand dollars for coverages not defined as disability insurance or basic hospital, medical and surgical insurance, or major medical insurance as defined in the National Association of Insurance Commissioners Health Insurance Shoppers' Guide, as of January 1, 2003, including any net cash surrender and net cash withdrawal values;

(II) Three hundred thousand dollars for disability insurance as defined in the National Association of Insurance Commissioners Health Insurance Shoppers' Guide, as of January 1, 2003;

(III) Five hundred thousand dollars for basic hospital, medical and surgical insurance, or major medical insurance as defined in the National

Association of Insurance Commissioners Health Insurance Shoppers' Guide, as of January 1, 2003; or

(iii) One hundred thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(b) With respect to each payee of a structured settlement annuity (or beneficiary or beneficiaries of the payee if deceased), one hundred thousand dollars in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;

(c) However, in no event may the association be obligated to cover more than (i) an aggregate of three hundred thousand dollars in benefits with respect to any one life under subsections 2(a), 2(b), and 2(c) of subpart C of this section except with respect to benefits for basic hospital, medical and surgical insurance, and major medical insurance under subsection 2(a)(ii) of this section, in which case the aggregate liability of the association may not exceed five hundred thousand dollars with respect to any one individual, or (ii) with respect to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than five million dollars in benefits, regardless of the number of policies and contracts held by the owner;

(d) The limitations set forth in this section are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this Act may be met by the use of assets

attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

D. In performing its obligations to provide coverage under section 8 of this Act, the association may not be required to guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

Section 4. This Act shall be construed to effect the purpose under section 2 of this Act.

Section 5. Terms used in this Act mean:

(1) "Account," either of the two accounts created under section 6 of this Act;

(2) "Association," the South Dakota Life and Health Insurance Guaranty Association described in section 6 of this Act;

(3) "Authorized assessment" or the term "authorized" when used in the context of assessments, means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed;

(4) "Benefit plan," a specific employee, union, or association of natural persons benefit plan;

(5) "Called assessment" or the term "called" when used in the context of assessments, means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers;

(6) "Contractual obligation," an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under section

3 of this Act;

(7) "Covered policy," a policy or contract or portion of a policy or contract for which coverage is provided under section 3 of this Act;

(8) "Director," the director of the Division of Insurance of this state;

(9) "Extra-contractual claims," include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys' fees and costs;

(10) "Impaired insurer," a member insurer which, after the effective date of this Act, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

(11) "Insolvent insurer," a member insurer which after the effective date of this Act, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

(12) "Member insurer," an insurer licensed or that holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under section 3 of this Act, and includes an insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include:

(a) A health maintenance organization;

(b) A fraternal benefit society;

(c) A mandatory state pooling plan;

(d) A mutual assessment company or other person that operates on an assessment basis;

(e) An insurance exchange;

(f) An organization engaged in the issuance of charitable gift annuities, which is described in § 58-1-16; or

(g) An entity similar to any of the above;

(13) "Moody's Corporate Bond Yield Average," the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto;

(14) "Owner" of a policy or contract and "policy owner" and "contract owner," the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms owner, contract owner, and policy owner do not include persons with a mere beneficial interest in a policy or contract;

(15) "Person," an individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization;

(16) "Premiums," amounts or considerations (by whatever name called) received on covered policies or contracts less returned premiums, considerations, and deposits and less dividends and experience credits. The term, premiums, does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under subpart B of section 3 except that assessable premium may not be reduced on account of subsection 3B(2)(c) relating to interest limitations and subdivision 3C(2) relating to limitations with respect to one individual, one participant, and one contract owner. Premiums do not include:

(a) Premiums on an unallocated annuity contract; or

(b) With respect to multiple nongroup policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of five million dollars with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner;

(17) "Principal place of business" of a plan sponsor or a person other than a natural person, the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

(a) The state in which the primary executive and administrative headquarters of the entity is located;

(b) The state in which the principal office of the chief executive officer of the entity is located;

(c) The state in which the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(d) The state in which the executive or management committee of the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(e) The state from which the management of the overall operations of the entity is directed; and

(f) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors. However, in the case of a plan sponsor, if more than fifty percent of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

The principal place of business of a plan sponsor of a benefit plan shall be deemed to be the principal place of business of the association, committee, joint board of

trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question;

(18) "Receivership court," the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer;

(19) "Resident," a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (i) residents of foreign countries, or (ii) residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this Act, shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts;

(20) "Structured settlement annuity," an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant;

(21) "State," a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate;

(22) "Supplemental contact," a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract;

(23) "Unallocated annuity contract," an annuity contract or group annuity certificate which is

not issued to an downed by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

Section 6. A. There is hereby continued the nonprofit legal entity known as the South Dakota Life and Health Insurance Guaranty Association as created by § 58-29C-1. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under section 10 of this Act and shall exercise its powers through a board of directors established under section 7 of this Act. For purposes of administration and assessment, the association shall maintain two accounts:

(1) The life insurance and annuity account which includes the following subaccounts:

(a) Life insurance account; and

(b) Annuity account which shall include annuity contracts owned by a governmental retirement plan (or its trustee) established under Section 401, 403(b), or 457 of the United States Internal Revenue Code; and

(2) The health insurance account.

B. The association shall come under the immediate supervision of the director and shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

Section 7. A. The board of directors of the association shall consist of not less than five nor more than nine member insurers serving terms as established in the plan of operation. The insurer members of the board shall be elected by member insurers subject to the approval of the director. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the director.

B. In approving selections or in appointing members to the board, the director shall consider,

among other things, whether all member insurers are fairly represented.

C. Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board may not otherwise be compensated by the association for their services.

Section 8. A. If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the director:

(1) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer; or

(2) Provide such moneys, pledges, loans, notes, guarantees, or other means as are proper to effectuate subdivision (1) and assure payment of the contractual obligations of the impaired insurer pending action under subdivision (1).

B. If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(1) (a) (i) Guaranty, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of the insolvent insurer; or

(ii) Assure payment of the contractual obligations of the insolvent insurer; and

(b) Provide moneys, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties; or

(2) Provide benefits and coverages in accordance with the following provisions:

(a) With respect to life and health insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits (except for terms of conversion and renewability) that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(i) With respect to group policies and contracts, not later than the earlier of the

next renewal date under those policies or contracts or forty-five days, but in no event less than thirty days, after the date on which the association becomes obligated with respect to the policies and contracts;

(ii) With respect to nongroup policies, contracts, and annuities not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but in no event less than thirty days, from the date on which the association becomes obligated with respect to the policies or contracts;

(b) Make diligent efforts to provide all known insureds or annuitants (for nongroup policies and contracts), or group policy owners with respect to group policies and contracts, thirty days notice of the termination (pursuant to subsection (a) of this subdivision) of the benefits provided;

(c) With respect to nongroup life and health insurance policies and annuities covered by the association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subsection (d), if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class;

(d) (i) In providing the substitute coverage required under subsection (c), the association may offer either to reissue the terminated coverage or to issue an

alternative policy;

(ii) Alternative or reissued policies shall be offered without requiring evidence of insurability, and may not provide for any waiting period or exclusion that would not have applied under the terminated policy;

(iii) The association may reinsure any alternative or reissued policy;

(e) (i) Alternative policies adopted by the association are subject to the approval of the domiciliary insurance director and the receivership court. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency;

(ii) Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that may not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but may not reflect any changes in the health of the insured after the original policy was last underwritten;

(iii) Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association;

(f) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the domiciliary insurance director and the receivership court;

(g) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date the coverage or policy is replaced by another similar policy by the policy owner, the insured, or the association;

(h) When proceeding under this subdivision B(2) with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with subsection 3B(2)(c).

C. Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy or coverage under this Act with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this Act.

D. Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association, and the association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

E. The protection provided by this Act does not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

F. In carrying out its duties under subpart B, the association may:

(1) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement, if the association finds that the amounts which can be assessed under this Act are less than the amounts needed to assure full and prompt performance of the association's duties under this Act, or that the economic or financial conditions as they affect member insurers are sufficiently adverse

to render the imposition of such permanent policy or contract liens, to be in the public interest;

(2) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

G. A deposit in this state, held pursuant to law or required by the director for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to §§ 58-29B-144 and 58-29B-149, shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association and not retained pursuant to this subpart. Any amount so paid to the association less the amount not retained by it shall be treated as a distribution of estate assets pursuant to § 58-29B-98 or similar provision of the state of domicile of the impaired or insolvent

insurer.

H. If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subpart B of this section, the director shall have the powers and duties of the association under this Act with respect to the insolvent insurer.

I. The association may render assistance and advice to the director, upon the director's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

J. The association shall have standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this Act or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the association, including proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association may also appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

K. (1) A person receiving benefits under this Act shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this Act, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The association may require an assignment to it of such rights and cause of action by any payee, policy, or contract owner, beneficiary, insured, or annuitant

as a condition precedent to the receipt of any right or benefits conferred by this Act upon the person.

(2) The subrogation rights of the association under this subpart shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this Act.

(3) In addition to subdivisions (1) and (2) of this subpart, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, or payee of a policy or contract with respect to the policy or contracts (including, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received pursuant to this Act, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code § 130).

(4) If the preceding provisions of this subpart are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies (or portion thereof) covered by the association.

(5) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in the preceding subdivisions of this subpart, the person shall pay to the association the portion of the recovery attributable to the policies (or portion thereof) covered by the association.

L. In addition to the rights and powers elsewhere in this Act, the association may:

(1) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this Act;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under section 9 of this Act and to settle claims or potential claims against it;

(3) Borrow money to effect the purposes of this Act; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(4) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this Act;

(5) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

(6) Exercise, for the purposes of this Act and to the extent approved by the director, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this Act;

(7) Organize itself as a corporation or in other legal form permitted by the laws of the state;

(8) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this Act with respect to the person, and the person shall promptly comply with the request; and

(9) Take other necessary or appropriate action to discharge its duties and obligations under this Act or to exercise its powers under this Act.

M. The association may join an organization of one or more other state associations of similar

purposes, to further the purposes and administer the powers and duties of the association.

N. (1) At any time within one year after the date on which the association becomes responsible for the obligations of a member insurer (the coverage date), the association may elect to succeed to the rights and obligations of the member insurer, that accrue on or after the coverage date and that relate to contracts covered (in whole or in part) by the association, under any one or more indemnity reinsurance agreements entered into by the member insurer as a ceding insurer and selected by the association. However, the association may not exercise an election with respect to a reinsurance agreement if the receiver, rehabilitator, or liquidator of the member insurer has previously and expressly disaffirmed the reinsurance agreement. The election shall be effected by a notice to the receiver, rehabilitator, or liquidator and to the affected reinsurers. If the association makes an election, subsections (a) to (d), inclusive, of this subdivision shall apply with respect to the agreements selected by the association:

(a) The association shall be responsible for all unpaid premiums due under the agreements (for periods both before and after the coverage date), and shall be responsible for the performance of all other obligations to be performed after the coverage date, in each case which relate to contracts covered (in whole or in part) by the association. The association may charge contracts covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association;

(b) The association is entitled to any amounts payable by the reinsurer under the agreements with respect to losses or events that occur in periods after the coverage date and that relate to contracts covered by the association (in whole or in part). However, upon receipt of any such amounts, the association is obliged to pay to the

beneficiary under the policy or contract on account of which the amounts were paid a portion of the amount equal to the excess of:

(i) The amount received by the association, over

(ii) The benefits paid by the association on account of the policy or contract less the retention of the impaired or insolvent member insurer applicable to the loss or event;

(c) Within thirty days following the association's election, the association and each indemnity reinsurer shall calculate the net balance due to or from the association under each reinsurance agreement as of the date of the association's election, giving full credit to all items paid by either the member insurer (or its receiver, rehabilitator, or liquidator) or the indemnity reinsurer during the period between the coverage date and the date of the association's election. Either the association or indemnity reinsurer shall pay the net balance due the other within five days of the completion of the aforementioned calculation. If the receiver, rehabilitator, or liquidator has received any amounts due the association pursuant to subsection (b), the receiver, rehabilitator, or liquidator shall remit the same to the association as promptly as practicable.

(d) If the association, within sixty days of the election, pays the premiums due for periods both before and after the coverage date that relate to contracts covered by the association (in whole or in part), the reinsurer is not entitled to terminate the reinsurance agreements insofar as the agreements relate to contracts covered by the association (in whole or in part) and is not entitled to set off any unpaid premium due for periods prior to the coverage date against amounts due the association.

(2) If the association transfers its obligations to another insurer, and if the association and the

other insurer agree, the other insurer shall succeed to the rights and obligations of the association under subdivision (1) effective as of the date agreed upon by the association and the other insurer and regardless of whether the association has made the election referred to above in subdivision (1) provided that:

(a) The indemnity reinsurance agreements shall automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary;

(b) The obligations described in the proviso to subsection (1)(b) of this subpart no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third party insurer; and

(c) This subdivision (2) does not apply if the association has previously expressly determined in writing that it will not exercise the election referred to in subdivision (1);

(3) The provisions of this subpart shall supersede the provisions of any law of this state or of any affected reinsurance agreement that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the coverage date, to the receiver, liquidator, or rehabilitator of the insolvent member insurer. The receiver, rehabilitator, or liquidator shall remain entitled to any amounts payable by the reinsurer under the reinsurance agreement with respect to losses or events that occur in periods prior to the coverage date (subject to applicable setoff provisions); and

(4) Except as otherwise expressly provided above, nothing herein alters or modifies the terms and conditions of the indemnity reinsurance agreements of the insolvent member insurer. Nothing herein abrogates or limits any rights of any reinsurer to claim that it is entitled to rescind a reinsurance agreement. Nothing herein gives a policy owner or beneficiary an

independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.

O. The board of directors of the association shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this Act in an economical and efficient manner.

P. Where the association has arranged or offered to provide the benefits of this Act to a covered person under a plan or arrangement that fulfills the association's obligations under this Act, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

Q. Venue in a suit against the association arising under the Act shall be in Hughes County. The association may not be required to give an appeal bond in an appeal that relates to a cause of action arising under this Act.

R. In carrying out its duties in connection with guaranteeing, assuming, or reinsuring policies or contracts under subpart A or B, the association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(1) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for (i) a fixed interest rate or (ii) payment of dividends with minimum guarantees or (iii) different methods for calculating interest or changes in value;

(2) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

(3) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

Section 9. A. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty days after prior written notice to the member insurers and shall accrue interest at ten percent per annum on and after the due date.

B. There shall be two classes of assessments, as follows:

(1) Class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under section 8 of this Act with regard to an impaired or an insolvent insurer.

C. (1) The amount of a Class A assessment shall be determined by the board and may be authorized and called on a pro rata or nonpro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments. The total of all nonpro rata assessments may not exceed one hundred fifty dollars per member insurer in any one calendar year. The amount of a Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(2) Class B assessments against member insurers for each account and subaccount shall be in

the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became insolvent (or, in the case of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available preceding the year in which the insurer became impaired) bears to premiums received on business in this state for those calendar years by all assessed member insurers.

(3) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be authorized or called until necessary to implement the purposes of this Act. Classification of assessments under subpart B and computation of assessments under this subpart shall be made with a reasonable degree of accurate, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

D. The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

E. (1) (a) Subject to the provisions of subsection (b) of this subdivision, the total of all assessments authorized by the association with respect to a member insurer for each

subaccount of the life insurance and annuity account and for the health account may not in one calendar year exceed two percent of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

(b) If two or more assessments are authorized in one calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subsection (a) of this subdivision shall be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

(c) If the maximum assessment, together with the other assets of the association in an account, does not provide in one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this Act.

(2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(3) If the maximum assessment for a subaccount of the life and annuity account in one year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subdivision C(2), the board shall access the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subdivision (1) of this section.

F. The board may, by an equitable method as established in the plan of operation, refund to

member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses claims.

G. It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this Act, to consider the amount reasonably necessary to meet its assessment obligations under this Act.

H. The association shall issue to each insurer paying an assessment under this Act, other than a Class A assessment, a certificate of contribution, in a form prescribed by the director, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the director may approve.

I. (1) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(2) Within sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional

time is required to resolve the issues raised by the protest.

(3) Within thirty days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the director.

(4) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the director for a final decision, with or without a recommendation from the association.

(5) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Interest on a refund due a protesting member shall be paid at the rate actually earned by the association.

J. The association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with a request.

Section 10. A. (1) The association shall submit to the director a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the director's written approval or unless it has not been disapproved within thirty days.

(2) If the association fails to submit a suitable plan of operation within one hundred twenty days following the effective date of this Act or if at any time thereafter the association fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Act. The rules shall continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall, in addition to requirements enumerated elsewhere in this Act:

(1) Establish procedures for handling the assets of the association;

(2) Establish the amount and method of reimbursing members of the board of directors under section 7 of this Act;

(3) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(4) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) Establish the procedures whereby selections for the board of directors will be made and submitted to the director;

(6) Establish any additional procedures for assessments under section 9 of this Act;

(7) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

D. The plan of operation may provide that any or all powers and duties of the association, except those under subdivision 8L(3) and section 9 of this Act, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subpart shall take effect only with the approval of both the board of directors and the director, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this Act.

Section 11. In addition to the duties and powers enumerated elsewhere in this Act,

A. The director shall:

(1) Upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer;

(2) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer shall constitute notice to its shareholders, if any; the failure of the insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under this Act;

(3) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

B. The director may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the director may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture may not exceed five percent of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars per month.

C. A final action of the board of directors or the association may be appealed to the director by a member insurer if the appeal is taken within sixty days of its receipt of notice of the final action being appealed. A final action or order of the director shall be subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that apply to the actions or orders of the director.

D. The liquidator, rehabilitator, or conservator of an impaired insurer may notify all interested persons of the effect of this Act.

Section 12. To aid in the detection and prevention of insurer insolvencies or impairments,

A. It shall be the duty of the director:

(1) To notify the directors of all the other states, territories of the United States and the District of Columbia within thirty days following the action taken or the date the action occurs, when the director takes any of the following actions against a member insurer:

(a) revocation of license;

(b) Suspension of license; or

(c) Makes a formal order that the company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners or creditors.

(2) To report to the board of directors when the director has taken any of the actions set forth in subdivision (1) or has received a report from any other director indicating that any such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another director.

(3) To report to the board of directors when the director has reasonable cause to believe from an examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer.

(4) To furnish to the board of directors the National Association of Insurance Commissioners Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the director or other lawful authority.

B. The director may seek the advice and recommendations of the board of directors concerning

any matter affecting the duties and responsibilities of the director regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

C. The board of directors may, upon majority vote, make reports and recommendations to the director upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. The reports and recommendations may not be considered public documents.

D. The board of directors may, upon majority vote, notify the director of any information indicating a member insurer may be an impaired or insolvent insurer.

E. The board of directors may, upon majority vote, make recommendations to the director for the detection and prevention of insurer insolvencies.

Section 13. A. A member insurer may offset against its premium tax liability to this state an assessment described in subpart 9H to the extent of twenty percent of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid. If the assessment is five hundred dollars or less, the member insurer shall take the total offset in the first year following the year in which the assessment was paid. However, total assessments offset against premium taxes may not exceed two million dollars in any year. If offsets exceed the annual limitation in this section, the excess may be carried forward to a subsequent year in which the annual limitation has not been exceeded. Any excess shall be apportioned among the contributing insurers in relation to their assessment that caused the limit to be exceeded. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

B. Any sums that are acquired by refund, pursuant to subpart 9F, from the association by member insurers, and that have been offset against premium taxes as provided in subpart A of this section, shall be paid by the insurers to this state in such manner as the tax authorities may require. The

association shall notify the director that refunds have been made.

Section 14. A. This Act may not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

B. Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under section 8 of this Act. The records of the association with respect to an impaired or insolvent insurer may only be disclosed upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subpart shall limit the duty of the association to render a report of its activities under section 15 of this Act.

C. For the purpose of carrying out its obligations under this Act, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to subpart 8K. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this Act. Assets attributable to covered policies, as used in this subpart, are that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

D. As a creditor of the impaired or insolvent insurer as established in subpart C of this section and consistent with § 58-29B-98, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this Act. If the liquidator has not, within one hundred twenty days of a final determination of insolvency of an insurer by the

receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

E. (1) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination, consideration shall be given to the welfare of the policy owners of the continuing or successor insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under section 8 of this Act with respect to the insurer have been fully recovered by the association.

F. (1) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under the order may recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of subdivisions (2) to (4), inclusive.

(2) No such distribution is recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) Any person who was an affiliate that controlled the insurer at the time the distributions were paid is liable up to the amount of distributions received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared, shall be liable up to the amount of distributions which would have been received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subpart shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(5) If any person liable under subdivision (3) is insolvent, all its affiliates that controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

Section 15. The association is subject to examination and regulation by the director. The board of directors shall submit to the director each year, not later than one hundred twenty days after the association's fiscal year, a financial report in a form approved by the director and a report of its activities during the preceding fiscal year. Upon the request of a member insurer, the association shall provide the member insurer with a copy of the report.

Section 16. The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

Section 17. There is no liability on the part of and no cause of action of any nature may arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the director or the director's representatives, for any action or omission by them in the performance of their powers and duties under this Act. Immunity shall extend to the participation in any organization of one or more other state associations of similar purposes

and to any such organization and its agents or employees.

Section 18. All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed sixty days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

Section 19. A. No person, including an insurer, agent, or affiliate of an insurer may make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circulate, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement, written or oral, which uses the existence of the Life and Health Insurance Guaranty Association of this state for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the South Dakota Life and Health Insurance Guaranty Association Act. However, this section does not apply to the South Dakota Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance.

B. Within one hundred eighty days of the effective date of this Act, the association shall prepare a summary document describing the general purposes and current limitations of the Act and complying with subpart C of this section. This document shall be submitted to the director for approval. At the expiration of the sixtieth day after the date on which the director approves the document, an insurer may not deliver a policy or contract to a policy or contract owner unless the summary document is delivered to the policy or contract owner at the time of delivery of the policy or contract. The document shall also be available upon request by a policy owner. The distribution,

delivery, or contents or interpretation of this document does not guarantee that either the policy or the contract or the owner of the policy or contract is covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to the Act may require. Failure to receive this document does not giver the policy owner, contract owner, certificate holder, or insured any greater rights than those stated in this Act.

C. The document prepared under subpart B shall contain a clear and conspicuous disclaimer on its face. The director shall establish the form and content of the disclaimer. The disclaimer shall:

(1) State the name and address of the Life and Health Insurance Guaranty Association and insurance department;

(2) Prominently warn the policy or contract owner that the Life ane Health Insurance Guaranty Association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this state;

(3) State the types of policies for which guaranty funds will provide coverage;

(4) State that the insurer and its agents are prohibited by law from using the existence of the Life and Health Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;

(5) State that the policy or contract owner should not rely on coverage under the Life and Health Insurance Guaranty Association when selecting an insurer;

(6) Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this Act; and

(7) Provide other information as directed by the director including sources for information about the financial condition of insurers provided that the information is not proprietary and is subject to disclosure under that state's public records law.

D. A member insurer shall retain evidence of compliance with subpart B for so long as the policy or contract for which the notice is given remains in effect.

Section 20. That §§ 58-29C-1 to 58-29C-43, inclusive, are repealed.

An Act to revise and update certain provisions related to the South Dakota Life and Health Insurance Guaranty Association.

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I certify that the attached Act originated in the

SENATE as Bill No. 56

_____
Secretary of the Senate

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_____
President of the Senate

Attest:

_____
Secretary of the Senate

_____
Speaker of the House

Attest:

_____
Chief Clerk

Senate Bill No. 56
File No. ____
Chapter No. _____

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Received at this Executive Office this _____ day of _____ ,

20____ at _____ M.

By _____
for the Governor

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The attached Act is hereby approved this _____ day of _____ , A.D., 20___

_____
Governor

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STATE OF SOUTH DAKOTA,
ss.
Office of the Secretary of State

Filed _____ , 20___
at _____ o'clock __ M.

_____
Secretary of State

By _____
Asst. Secretary of State